IHIC
Valued Based Reimbursement

July 9, 2009

Charge to Value-Based Subcommittee

- **Vision:** By 2010, 75% of the insured population of Indiana will be members of commercial or government payors who are participants in the Quality Health First (QHF) program with publicly available outcomes-based reporting
- **Proposed IHIC Goals**:
  - IHIC will facilitate expanding participation among payors and physicians across the state through employer & other stakeholder education & advocacy
  - IHIC will identify barriers to physician participation and advocate for needed policy changes including Medicaid reimbursement or legislative changes
  - IHIC will work with the Indiana Congressional delegation to advocate for legislation which enables Medicare data sharing statewide
  - IHIC will form a workgroup made up of subject matter experts from Indiana stakeholder organizations to define, by July 2009, action plans to meet the board's goals for this vision.

Subcommittee Members

David Kelleher	Employers' Forum
David Lee, M.D.	Anthem
Gregory Larkin, M.D.	IHIE
David Wulf	Templeton Coal
Vicki Perry	Advantage Health Solutions
Caroline CarneyDoebbling, M.D.	OMPP
Bernice Ulrich	IHHA
Gordon Hughes, M.D.	Practicing Physician

Other Participants:

Kent Barth, Becky Robinson, Jason Vore and John Kansky

Preliminary Update

Committee met twice:

- Determined that the goal (75% of the insured population will be QHF members by 2010) is not realistic. Needs to be extended.
- The rest of the first meeting and all of the second were consumed with a debate about including Medicaid in the QHF program – without resolution.

QHF – goals and purposes

- Eliminate dueling report cards. Carriers were in the process of developing quality reports that:
  - measured only a small portion of a typical physician's practice
  - were operationalized differently
  - had poor feedback loops (physicians' ability to correct errors) and
  - included different measures.
- Achieve credibility at the level of the individual physician or group
- Require quality-based P4P and align carrier performance payments so that there is overlap in the quality metrics that are incented. There was no coordination among carriers as to the measures they were incenting and no forum for this discussion to happen.

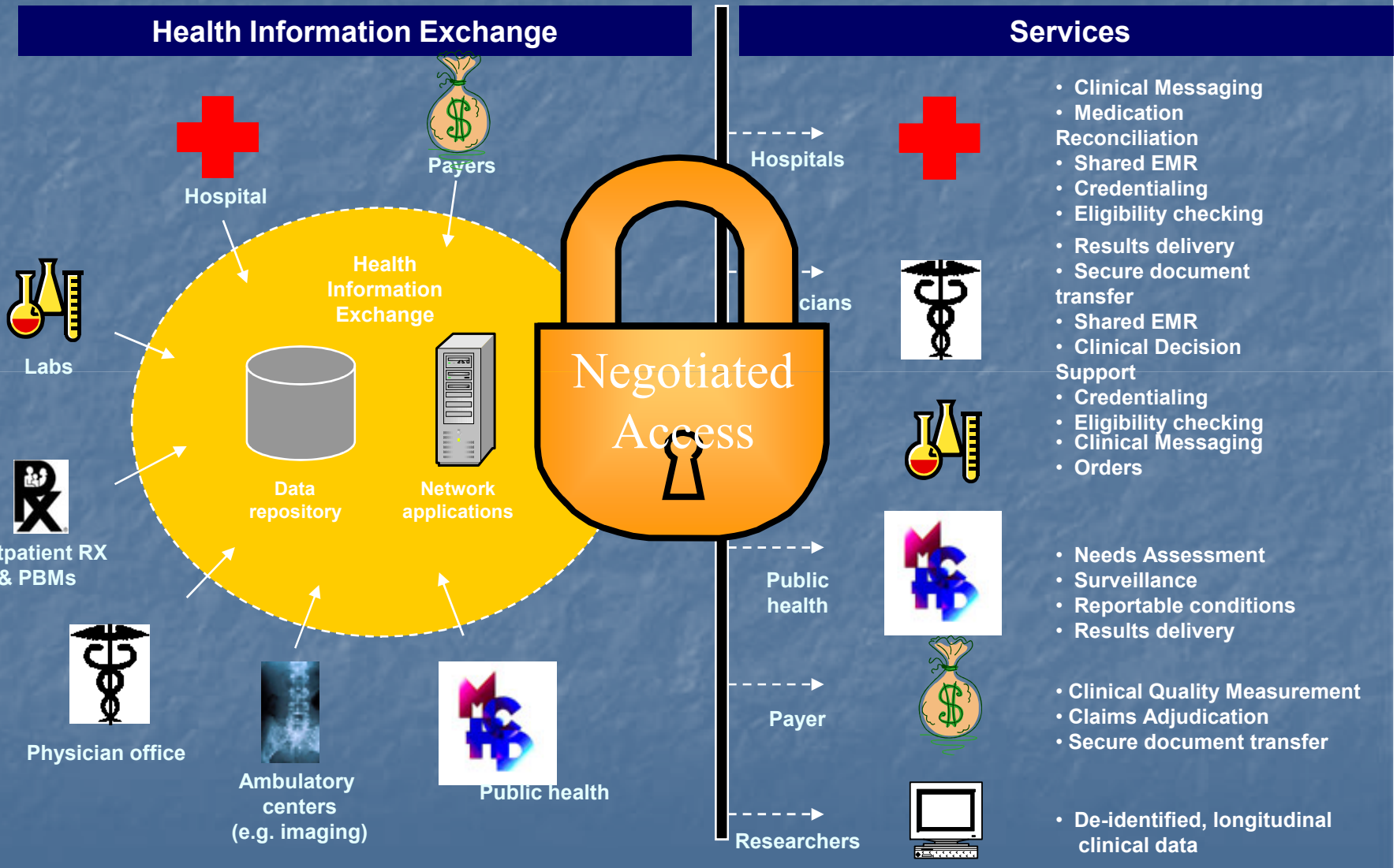
QHF – goals and purposes

- Raise all boats – base incentives from all parties on the results across all populations.
- Provide a disease registry for physicians without significant intrusion into the physician's office practice.
- Earn physician support for quality improvement – involvement and neutrality
- Provide actionable physician-level reports, alerts and reminders across all populations.

Implementation

- Physicians / health plans choose measures
- Non-intrusive acquisition of information:
  - Claims
  - INPC - HIE
  - EMR
  - Selected lab values reported by practices
- Error correction by physicians
- Relatively small # of initial measures:
  - Overlapping provider incentives from multiple carriers
  - Encourage rapid improvement
  - Add measures over time (also required by Medicare)

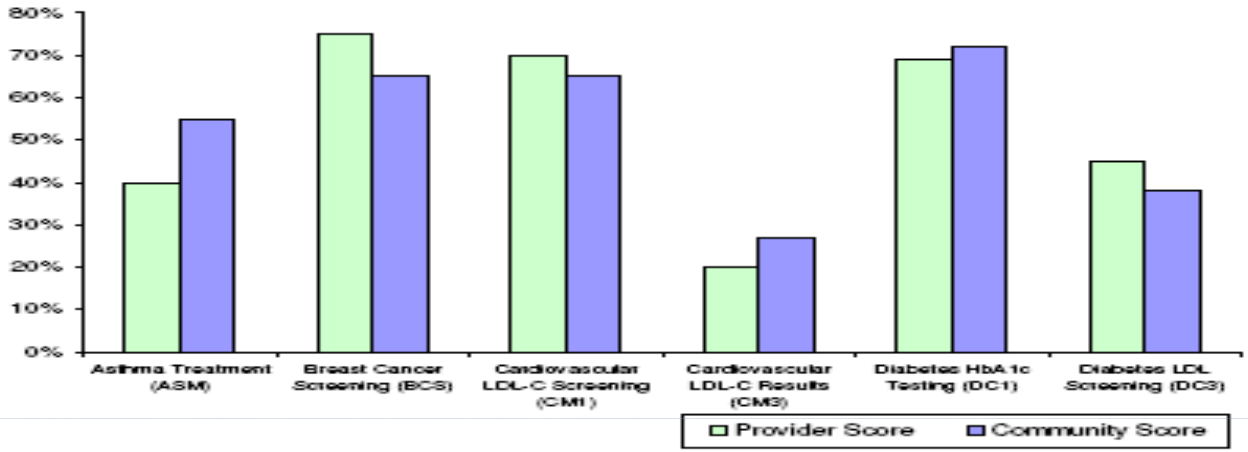
Health Information Exchange Services



Indiana Health Information Exchange

Quality Health First ® Program

[Provider Name] (QHF Id# 12345) of [Physician Group Name]
Provider Summary for [As Of Date]



Patients Due To Be Seen

	Asthma Treatment (ASM)	Breast Cancer Screening (BCS)	Cardiovascular LDL-C Screening (CM1)	Cardiovascular LDL-C Results (CM3)	Diabetes HbA1c Testing (DC1)	Diabetes LDL Screening (DC3)
Overdue	56	157	22	26	31	23
Coming Due	26	68	15	19	25	17

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Indiana Health Information Exchange

Quality Health First® Program

Patient Care View as of 4/30/2008

Dr. A[redacted]d (ID #1004) From [redacted] Group Primary Care

QHF ID:	[redacted]	**Last Name:** [redacted]	**Gender: Male**
DOB:	[redacted]	**First Name:** [redacted]	**Age: 64 yr**

Alerts

Cholesterol Management for Patients with Cardiovascular Conditions

Measure	Description	Notes
CM1	LDL-C Screening	Last LDL-C Screening on Mar 1 2007 according to Wishard Memorial Hospital not within 12 months
CM3	LDL-C Controlled (<100 mg/dL)	Last LDL-C Screening on Mar 1 2007 according to Wishard Memorial Hospital not within 12 months

☐ Did not have an AMI, Coronary Artery Bypass Graft, Percutaneous Transluminal Coronary Angioplasty, or Ischemic Vascular Disease

LDL Test Date ☐☐/☐☐/☐☐☐☐ LDL Test Result (mg/dL) ☐☐☐.☐☐

Colorectal Cancer Screening

Measure	Description	Notes
COL	Colorectal Cancer Screening	No Record of Colorectal Cancer Screening on file

Colonoscopy Date ☐☐/☐☐/☐☐☐☐ Flexible Sigmoidoscopy Date ☐☐/☐☐/☐☐☐☐ Double Contrast Barium Enema Date ☐☐/☐☐/☐☐☐☐

Fecal Occult Blood Test Date ☐☐/☐☐/☐☐☐☐ Total Colectomy Date ☐☐/☐☐/☐☐☐☐ Colorectal Cancer Diagnosis Date ☐☐/☐☐/☐☐☐☐

Comprehensive Diabetes Care

Measure	Description	Notes
DC1	HbA1c Testing	No Record of HbA1c Testing on file
DC2	HbA1c Controlled (<=9%)	No Record of HbA1c Controlled (<=9%) on file
DC3	LDL-C Screening	No Record of LDL-C Screening on file
DC5	LDL-C Controlled (<100 mg/dL)	No Record of LDL-C Controlled (<100 mg/dL) on file
DC7	Retinal Eye Exam	No Record of Retinal Eye Exam on file
DC8	HbA1c Well Controlled (<7%)	No Record of HbA1c Well Controlled (<7%) on file

☐ Does Not Have Diabetes

HbA1c Test Date ☐☐/☐☐/☐☐☐☐ HbA1c Test Result (%) ☐☐.☐☐ LDL Test Date ☐☐/☐☐/☐☐☐☐ LDL Test Result (mg/dL) ☐☐☐.☐☐

ACE/ARB Therapy Date ☐☐/☐☐/☐☐☐☐ Nephropathy Treatment Date ☐☐/☐☐/☐☐☐☐ Microalbumin Test Date ☐☐/☐☐/☐☐☐☐

Macroalbumin Test Date ☐☐/☐☐/☐☐☐☐ Macroalbumin Test Result ☐1+ ☐2+ ☐3+ ☐4+ Retinal Eye Exam Date ☐☐/☐☐/☐☐☐☐ Eye Exam Result ☐ - ☐ +

Polycystic Ovary Disease Diagnosis Date ☐☐/☐☐/☐☐☐☐ Gestational Diabetes Diagnosis Date ☐☐/☐☐/☐☐☐☐ Steriod Induced Diabetes Diagnosis Date ☐☐/☐☐/☐☐☐☐

Physician Name

	Quality Measures	Measures Not Met	Medicare			Medicaid			Participating Commercial			Combined Score			Unknown Population	Overall Population
			Population	Percentage Met	Program % Met	Population	Percentage Met	Program % Met	Population	Percentage Met	Program % Met	Population	Percentage Met	Program % Met		
Asthma Treatment																
ASM	Use of Appropriate Medications for People with Asthma	48				140	77.9%	75.6%	118	85.6%	78.6%	258	81.4%	77.1%	147	405
Children's Health																
W15	Well-Child Visits Birth– 5 Months	2				13	92.3%	90.4%	11	90.9%	89.5%	24	91.7%	90.0%	12	36
W34	Well-Child Visits 3–6	6				12	58.3%	59.4%	15	80.0%	75.6%	27	70.4%	67.5%	18	45
AWC	Adolescent Well-Care Visits	8				15	66.7%	64.2%	21	85.7%	82.4%	36	77.8%	73.3%	17	53
CIS	Childhood Immunization Status	5				17	82.4%	81.6%	16	87.5%	82.7%	33	84.8%	82.2%	21	54
AIS	Adolescent Immunization Status	9				18	72.2%	73.4%	22	81.8%	79.6%	40	77.5%	76.5%	17	57
CWP	Appropriate Testing for Children with Pharyngitis	5				17	82.4%	80.8%	16	87.5%	81.6%	33	84.8%	81.2%	19	52
URI	Appropriate Treatment for Children with URI	5				17	82.4%	79.7%	16	87.5%	80.4%	33	84.8%	80.1%	21	54
Diabetic Care																
DC1	HbA1c Testing	11	40	90.0%	86.4%	32	84.4%	82.1%	37	94.6%	82.1%	109	89.9%	83.5%	35	144
DC8	HbA1c Good Control <7%	38	40	62.5%	68.5%	32	59.4%	67.4%	37	73.0%	74.6%	109	65.1%	70.2%	35	144
DC3	LDL-C Screening	14	40	95.0%	87.1%	32	78.1%	82.4%	37	86.5%	84.4%	109	87.2%	84.6%	35	144
DC5	LDL-C Controlled <100 mg/dL	37	40	70.0%	72.0%	32	56.3%	69.9%	37	70.3%	71.6%	109	66.1%	71.2%	35	144
DC6	Kidney Disease Monitored	28	40	85.0%	81.0%	32	53.1%	78.1%	37	81.1%	79.4%	109	74.3%	79.5%	35	144
DC7	Retinal Eye Exam	17	40	92.5%	89.4%	32	75.0%	72.6%	37	83.8%	73.9%	109	84.4%	78.6%	35	144
Heart Health																
BBH	Ambulatory Beta-Blocker Treatment	32	38	73.7%	78.2%	31	41.9%	66.5%	36	88.9%	87.2%	105	69.5%	77.3%	41	146

Challenges to Growth

QHF is not statewide. Current growth path is community-by-community as clinical information becomes available.

- Dependent upon growth of INPC and/or local HIEs or rapid development of EMRs connected to QHF
- Requires payers to have two physician reimbursement/ incentive systems
  - One within QHF areas and another without
- Timing of growth along this path is not under the control of payers or IHIE

Challenges to Growth

QHF does not serve all of the quality reporting needs of health plans/ payers:

- Some QHF definitions do not perfectly coincide with HEDIS definitions
  - Physician input
  - Multi-carrier participation with focus on physician, not payer
- QHF does not produce all HEDIS measures
- QHF does not use survey information (needs credibility at doctor, not plan level)

Specific Challenges with Indiana Medicaid

- Medicaid's incentive system is focused on health plans, not providers
- Large number of measures used - not focused on a few
- Strict HEDIS definitions used because $ are tied to performance for each plan
- Value of focusing provider attention on a small number of important quality measures across carriers is attenuated:
  - Many Medicaid providers do not serve large commercial populations
  - Metrics important to Medicaid may differ from those important to commercial and Medicare populations

How QHF might grow

- Work with participating payers to develop a two-stage incentive system:
  - Multi-carrier, claims based quality metrics in all areas
  - Claims plus clinical information in full QHF areas
- Develop ability to provide HEDIS reporting on a statewide basis:
  - Claims-based incidence reports for all carriers/payers
  - Supplemented by carrier-provided survey-obtained clinical information (credible at the plan level) in areas where QHF is not fully developed
  - Integrated with QHF-provided clinical information in QHF areas

How IHIC might help (subcommittee has not yet discussed)

- Promote the growth of INPC
  - Find funding for data repository
  - Find a way to encourage other HIE's to participate
  - Find ways to encourage all providers (commercial labs, imaging centers, hospitals and physicians) to contribute information to INPC
- Determine whether state Medicaid can participate in QHF:
  - Address apparent redundancy – data and $
  - Address MCO provider incentive systems
- Develop statewide Medicare DUA jointly with IHIE

What we want for Indiana

- Trusted independent source of information
- The majority of our citizens are covered by quality reports (i.e., a majority of a provider's patients)
- Clinical information is included and reports are credible at the level of the individual physician
- Rapid improvement in selected metrics with P4P focus across carriers/ populations
- Ability to become a statewide or even regional solution – with carrier/payer support
- Transportable agreements with laboratories, hospitals, PBMs, carriers
- Other value added: PQRI, RWJF, EMR stimulus

Need Direction from IHIC Board

- The committee can't resolve the issue of Medicaid participation in QHF - this needs to be discussed directly between the parties
- QHF is the only functioning program with multi-payer support that satisfies the charge to the subcommittee.
- Questions:
  - Should we reconvene the workgroup and concentrate on how IHIE can help grow QHF as a commercial-Medicare program?
  - Should I provide recommendations to IHIC informed by the discussion/input of the subcommittee?
  - Or something else?